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**JAN Classic article: Mental illness, mental handicap and the nursing service establishment – an alternative approach**

Nursing for people with mental health problems was very different 40 years ago. Although British minister of health Enoch Powell had signalled the demise of the former asylums in a speech in 1961, a decade later, these large institutions continued to house over a 100,000 patients. Community psychiatric nurses were rare. In an economy of scale, care was provided with 'few frills' and, at the time of the article reviewed here (Walsh 1976), the mental hospitals were mired in scandals (Martin 1984).

In the first 20 years of the UK National Health Service, launched after the Second World War, Britain was almost bankrupt, and services for the mentally ill were not prioritised. In the 1960s the government was shamed into investing in the decaying system. Acute psychiatric units were built in new district general hospitals, but this left an ageing and neglected population in the outmoded mental hospitals. Recruitment to such settings was becoming more difficult, necessitating reliance on the former colonies for work eschewed by local people. Quality of care in the 'back wards' was typically poor, and the corruption and abuse exposed by investigations at hospitals such as Whittingham and St Augustine's could no longer be ignored.

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A spate of enquiries in the 1970s emphasised the need for effective nursing leadership, and rational workforce planning to adapt mental health services to changing patterns of demand. As Walsh (1976) explained, most research on staffing levels was in general hospitals. This imbalance persists, producing numerical guidelines that do not fit the mental health context. The government had issued a minimal staffing ratio in mental institutions, but these were simply to ensure provision of basic care and containment (Department of Health & Social Security 1972). However, the gradually declining population helped to improve the nurse-patient ratio.

Walsh (1976) argued that staffing in mental hospitals should not follow the task-orientated metric of general hospitals, but should relate to therapeutic process. He criticised passive acceptance of the medical model by nurses, who thus excused themselves from responsibility for patients' treatment.

To shift focus from disease to the person, Walsh proposed a behavioural model of nursing.

Functional analysis of patients' problems would guide setting of goals, aiming towards recovery and discharge.

For nurses trained in the late twentieth century, the term 'model' has negative connotations.

Nursing models, such as that of Roper *et al.* (1981), generally failed to improve practice, and were mostly abandoned in nurse training. Tuned to the doctrine of evidence-based practice, current nursing students are oblivious to the work of nursing theorists, but the baby was thrown out with the bathwater. Purposeful therapeutic engagement cannot rely on empiricist research alone; it should also be guided by established and emerging theory on the nature of self, distress and recovery (McCrae 2012). What are nurses trying to achieve, and why?

Behavioural methods were common in the mental hospitals when Walsh was writing. Rehabilitation units, mostly accommodating schizophrenic patients who had languished in long-stay wards, were essentially behaviourist. Token economy systems were applied, individually or collectively.

Outcomes were readily measurable, making nurses more accountable for their work. Ridiculing psychoanalytic conjecture, Walsh urged nurses to record only what they witnessed, maintaining a treatment regime 'based on fact'. Arguably, this perpetuated the notion that nurses observe, but only doctors explain (Chung & Nolan 1994).

Inevitably, therapeutic approaches based on learning theory became mechanistic, reinforcing the objectification of patients and their problems. Often, means and ends were conflated, with spurious improvements achieved. Nurses were expected to maintain copious records of patients' progress, and not surprisingly some programmes, normally devised by a psychologist, were sabotaged (McCrae & Nolan 2016). Desired outcomes were heavily influenced by the priorities of ward management, and were individualised merely on the ability of each patient to contribute to the daily routine, such as clearing the tables after mealtimes. Rewards were ethically dubious, with patients' own cigarettes exploited as currency.

Walsh may have been naïve in his expectations of a behavioural system, but his paper had value in drawing attention to a fundamental conflict in mental health nursing. This is perhaps best conceptualised by philosopher Martin Buber's (1937) distinction between instrumentalism and commitment. Much of nursing is instrumental, including crucial tasks such as administration of medicine. However, task-orientation may be dehumanising, diverting nursing from its core principles. Commitment, by contrast, is to engage with the patient as a fellow human being, showing empathy, compassion and genuine interest in his or her plight. Ideally, nursing is holistic, integrating physical procedures with humanistic endeavour, but instrumentalism is often the dominant partner in an awkward dualism.

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Acute psychiatric wards present a perennial picture of this tension in nursing. Admitted in a state of severe disturbance or despair, patients have pronounced need for supportive and therapeutically-adept nursing care, but in reality they receive limited input of the commitment type. Nursing in such wards is extremely challenging, and there are genuine constraints on the time afforded for developing therapeutic relationships: high turnover, raised threshold for admission due to bed shortages, and staffing shortages. Some nurses retreat to the comfort zone of the office, leaving patients feeling abandoned. Days are long, and the devil makes work for idle hands: boredom is a factor in violent incidents. Recently, one of the author's students produced an insightful observation of daily life in an acute psychiatric ward, highlighting the Kafkaesque norms that prevail (McCrae 2016).

In acute psychiatric care, behaviourism remains evident, but in a crude and counterproductive form. Compliance is rewarded, but perverse incentives are also evident. Visit a psychiatric ward and you will normally see two or three patients lurking around the nurses' station, waiting for something. To get attention, patients must seek it, and as requests are often ignored, they may resort to aggressive behaviour. Sometimes this results in a forced injection and seclusion under close observation; thus attention is maximised.

Nurses must demonstrate their value as skilled practitioners. They are not merely an accessory to biomedical hegemony, whereby treatment means drugs, with perhaps brief psychological therapy on the side. Although nurses have an important therapeutic role, the system inhibits their contribution. The pace in psychiatric wards is too fast, and should be slowed to allow care that is primarily psychosocial rather than medical. As Walsh (1976) recommended, staffing levels should relate to desired therapeutic outcomes, not simply administrative convenience. Transformation in mental health care needs investment and energy, but ultimately will be better for patients, and more rewarding for nurses.

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